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15. Family or caregiver training.

16. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care recipients who are eligible for such services.

L. Contract Termination. The specialized care provider contract shall be terminated upon the demonstration of one or more of the following conditions:

1. The provider is no longer certified to participate in the Medicare or Medicaid programs.

2. The provider violates provisions of the written contract for specialized care.

3. The provider gives written notice to DMAS at least 30 days in advance that it wishes to terminate the contract.

D. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutions for Mental Disease (IMD)

1. With respect to each Medicaid-eligible resident in an ICF/MR or IMD in Virginia, a written plan of care must be developed prior to admission to or authorization of benefits in such facility, and a regular program of independent professional review (including a medical evaluation) shall be completed periodically for such services. The purpose of the review is to determine: the adequacy of the services available to meet his current health needs and promote his maximum physical well being, the necessity and desirability of his continued placement in the facility; and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Long-term care of residents in such facilities will be provided in accordance with Federal law that is based on the resident's medical and social needs and requirements.

2. With respect to each ICF/MR or IMD, periodic on-site inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), shall be conducted. The review shall include, with respect to each recipient, a determination of the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, the necessity and desirability of continued placement in the facility, and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Full reports shall be made to the State agency by the review team of the findings of each inspection, together with any recommendations.

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3. In order for reimbursement to be made to a facility for the mentally retarded, the resident must meet criteria for placement in such facility as described in Supplement 1, Part 4, to Attachment 3.1-C and the facility must provide active treatment for mental retardation.

4. In each case for which payment for nursing facility services for the mentally retarded or institution for mental disease services is made under the State Plan:

   a. a physician must certify for each applicant or recipient that inpatient care is needed in a facility for the mentally retarded or an institution for mental disease. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

   b. a physician, or physician assistant or nurse practitioner acting within the scope of the practice as defined by State law and under the supervision of a physician, must recertify for each applicant at least every 365 days that services are needed in a facility for the mentally retarded or institution for mental disease.

5. When a resident no longer meets criteria for facilities for the mentally retarded or an institution for mental disease or no longer requires active treatment in a facility for the mentally retarded, then the resident must be discharged.

6. All services provided in an IMD and in an ICF/MR shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

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12 VAC 30-60-60. Repealed. [Psychiatric Services resulting from an EPSDT screening.]

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12 VAC 30-60-60. *Repealed.*
12 VAC 30-60-61.

E. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

1. Community mental health services for children.

a. Intensive in-home services for children and adolescents:

(1) Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

(a) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

(b) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.

(c) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

(2) At admission, an appropriate assessment is made and documented that service needs can best be met through intervention provided typically but not solely in the client's residence; service must be recommended in the Individual Service Plan (ISP) which must be fully completed within 30 days of initiation of services.

(3) Services must be delivered primarily in the family's residence. Some services may be delivered while accompanying family members to community agencies or in other locations.

(4) Services shall be used when out-of-home placement due to the clinical needs of the child is a risk and either:

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(a) Services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation; or

(b) when the child's residence as the setting for services is more likely to be successful than a clinic.

(5) Services are not appropriate for a family while the child is absent from the home.

(6) Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The child and responsible parent/guardian must be available and in agreement to participate in the transition.

(7) At least one parent or responsible adult with whom the child is living must be willing to participate in in-home services, with the goal of keeping the child with the family.

(8) The provider of intensive in-home services for children and adolescents must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

(9) The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, in-home services is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of five hours a week of intensive in-home service, and includes a plan for service provision of a minimum of five hours of service delivery per client/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the client and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Intensive in-home services below the five hour a week minimum may be covered. However, variations in this pattern must be consistent with the individual service plan. Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive and/or non-home based services.

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(10) The intensity of service dictates that caseload sizes should be six or fewer cases at any given time. If on review caseloads exceed this limit, the provider will be required to submit a corrective action plan designed to reduce caseload size to the required limit unless the provider can demonstrate that enough of the cases in the caseload are moving toward discharge so that the caseload standard will be met within three months by attrition. Failure to maintain required caseload sizes in two or more review periods may result in termination of the provider agreement unless the provider demonstrates the ability to attain and maintain the required caseload size.

(11) Emergency assistance shall be available 24 hours per day, seven days a week.

b. Therapeutic day treatment for children and adolescents.

(1) Therapeutic day treatment is appropriate for children and adolescents who meet one of the following:

(a) Children and adolescents who require year-round treatment in order to sustain behavior or emotional gains.

(b) Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:

(i) this programming during the school day; or

(ii) this programming to supplement the school day or school year.

(c) Children and adolescents who would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.

(d) Children and adolescents who have deficits in social skills, peer relations, dealing with authority; are hyperactive; have

poor impulse control; are extremely depressed or marginally connected with reality.

(e) Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that they cannot function in these programs without additional services.

(2) Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

(a) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

(b) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.

(c) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

(3) The provider of therapeutic day treatment for child and adolescents services must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

(4) The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

(5) The program must operate a minimum of two hours per day and may offer flexible program hours (i.e., before and/or after school and/or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five

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or more hours of service in a given day.

(6) Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

(7) Services shall be provided following a diagnostic assessment when authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker or certified psychiatric nurse and in accordance with an ISP which must be fully completed within 30 days of initiation of the service.

I. Home Health Services

1. Home health services which meet the standards prescribed for participation under Title XVIII will be supplied.

2. Home health services shall be provided by a licensed home health agency on a part-time or intermittent basis to a homebound recipient in his place of residence. The place of residence shall not include a hospital or nursing facility. Home health services must be prescribed by a physician and be part of a written plan of care utilizing the Home Health Certification and Plan of Treatment forms which the physician shall review at least every 62 days.

3. Except in limited circumstances described in subsection 4 below, to be eligible for home health services, the patient must be essentially homebound. The patient does not have to be bedridden. Essentially homebound shall mean:

   a. the patient is unable to leave home without the assistance of others who are required to provide medically necessary health care interventions or the use of special medical equipment;

   b. the patient has a mental or emotional problem which is manifested in part by refusal to leave the home environment or is of such a nature that it would not be considered safe for him to leave home unattended;

   c. the patient is ordered by the physician to restrict activity due to a weakened condition following surgery or heart disease of such severity that stress and physical activity must be avoided;

   d. the patient has an active communicable disease and the physician quarantines the patient.

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3. Except in limited circumstances described in subsection 4 below, to be eligible for home health services, the patient must be essentially homebound. The patient does not have to be bedridden. Essentially homebound shall mean:

   a. the patient is unable to leave home without the assistance of others who are required to provide medically necessary health care interventions or the use of special medical equipment;

   b. the patient has a mental or emotional problem which is manifested in part by refusal to leave the home environment or is of such a nature that it would not be considered safe for him to leave home unattended;

   c. the patient is ordered by the physician to restrict activity due to a weakened condition following surgery or heart disease of such severity that stress and physical activity must be avoided;

   d. the patient has an active communicable disease and the physician quarantines the patient.

4. Under the following conditions, Medicaid will reimburse for home health services when a patient is not essentially homebound. When home health services are provided because of one of the following reasons, an explanation must be included on the Home Health Certification and Plan of Treatment forms:

   a. when the combined cost of transportation and medical treatment exceeds the cost of a home health services visit;

   b. when the patient cannot be depended upon to go to a physician or clinic for required treatment, and, as a result, the patient would in all probability have to be admitted to a hospital or nursing facility because of complications arising from the lack of treatment;

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c. when the visits are for a type of instruction to the patient which can better be accomplished in the home setting;

d. when the duration of the treatment is such that rendering it outside the home is not practical.

5. Covered Services: Any one of the following services may be offered as the sole home health service and shall not be contingent upon the provision of another service.

a. Nursing services

b. Home health aide services

c. Physical therapy services

d. Occupational therapy services

e. Speech-language pathology services

f. Medical supplies, equipment, and appliances suitable for use in the home.

6. General Conditions. The following general conditions apply to skilled nursing, home health aide, physical therapy, occupational therapy, and speech-language pathology services provided by home health agencies.

a. The patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license. The physician may be the patient's private physician or a physician on the staff of the home health agency or a physician working under an arrangement with the institution which is the patient's residence or, if the agency is hospital-based, a physician on the hospital or agency staff.

b. Services shall be furnished under a written plan of care and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of care and must be related to the patient's condition. The written plan of care shall appear on the Home Health Certification and Plan of Treatment forms.